STATE OF CALIFORNIA – Health and Human Services Agency | Department of Mental Health

SHORT-DOYLE/MEDI-CAL MONTHLY CLAIM FOR
REIMBURSEMENT – ADMINSTRATIVE COST
MH1982 B (Rev. 09/00)

(See instruction on reverse side)

Date	County Code	County
Fiscal Year	Claim For **MO/YR**	

SD/MC Direct Facility Cost:

1	County Providers	
2	Contract Providers *(including LACDHS)*	
3	Phase I Consolidation Hospital Inpatient Costs	
4	Total SD/MC Direct Facility Costs	
5	Administration Percentage (DO NOT exceed 15%)	
6	Calculated SD/MC Administrative Costs	
7	Actual SD/MC Administrative Costs (if available)	
8	Enter the smaller of line 5 or 6	
9	Federal Financial Participation (50.00% of Approved Amount – Lower of line 6 or 7)	

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Community Mental Health Services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1098 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Chapter 3, Part 2, Division 5 of the Welfare and Institutions Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County agrees and shall certify under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the County. The services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan. The County shall also certify that all information submitted to the Department is accurate and complete. The County understands that payment of these claims will be from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. The County agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extend of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services the Medi-Cal Fraud Unit, California Department of Mental Health, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex age, or physical or mental disability.

Date: _____ Signature: _____
Local Mental Health Director

Executed at _____, California

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official, as delegated by the Board of supervisors, of the herein claimant responsible for the examination and settlement of accounts. I further certify that claimant will provide the State's share of payment for Short-Doyle/Medi-Cal covered services included in this claim in order to satisfy matching requirements for federal financial participation pursuant to the Title XIX of the Social Security Act.

Date: _____ Signature: _____

Title: _____ Executed at _____, California
(County Auditor-Controller, City Finance Officer,
or Local Mental Health Accounting Officer)

FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY

1. County Administrative Cost Claim for Reimbursement $ _____

Signature: _____ Date: _____
Accounting Office

Schedule No:_____

INSTRUCTIONS FOR COMPLETING MH 1982 B

Line 1 Enter monthly direct facility costs of providing Short-Doyle/Medi-Cal (SDMC) services for all county providers from the MH 1980 worksheets, disk, or tape.

Line 2 Enter monthly direct facility costs of providing SD/MC services for contract providers from the MH 1980 worksheets, disk, or tape.

Line 3 Add lines 1 and 2.

Line 4 Enter percentage, not to exceed 15%. A Value less than 15% may be appropriate for a county where actual SD/MC administrative costs are expected to be below the maximum allowable administrative costs.

Line 5 Multiply line 3 by line 4.

Line 6 Enter actual SD/MC administrative costs, if available. Otherwise, leave it blank.

Line 7 Enter the smaller of line 6 (if not blank) or line 5. This amount represents the monthly SD/Mc administrative claim.

Submit this claim to:

Department of Mental Health
Accounting Section
1600 9th Street, Room 150
Sacramento, CA 95814